Kansas Medical Assistance Program Prior Authorization Request Form for Non-Preferred Drugs

If you would like to prescribe a Preferred Drug, Please do so in the space provided and **FAX form back to the dispensing pharmacy**. Otherwise, continue with the Prior Authorization process by completing the rest of this form & FAX completed form to the Prior Authorization Unit @ 1-800-913-2229 (274-5956 Topeka)	**Rx** _____ Physician signature _____ Date

Growth Hormone **Clinical Prior Authorization is still required for all Growth Hormones*	
Preferred Drug Covered	**Non-preferred Prior Authorization Required**
Somatropin Tev-Tropin®	Somatropin Genotropin® Humatrope® ** Includes all alternative delivery systems and formulations Norditropin® Nutropin® Saizen®

** **Indicates REQUIRED information**

****CONSUMER NAME:** _____ ****Medicaid Number:**_____

****PHARMACY NAME:**_____ ****Medicaid Number:**_____

****Phone Number:**_____ ****Fax Number:**_____ ****NDC:**_____

****PRESCRIBING PHYSICIAN NAME:**_____ ****Medicaid Number:**_____

****Phone Number:**_____ ****Fax Number:**_____

☐ ** **Absence of appropriate indication of the drug.** Please specify:_____

_____

_____

_____

_____

_____

_____

****Prescribing Physician's signature:** _____**Date:** _____

If the pharmacy provider has started a Prior Authorization request and this information is not received within 15 working days, the PA request will be denied. **For questions related to Prior Authorization, contact 800-285-4978, option #3 or 274-5499, in Topeka.** General support is provided at 800-933-6593. For questions related to pharmacy issues, contact the Pharmacy Help Desk toll-free at 866-405-5200.

Kansas Medical Assistance Programs

HEALTHCONNECT Kansas
From the office of the Fiscal Agent

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

P.O. Box 3571, Topeka KS 66601-3571
Prior Authorization: 1-800-285-4978 or 785-274-5499
Prior Authorization Fax Lines: 1-800-913-2229 or 785-274-5956

CHILDREN INITIAL GROWTH HORMONE REQUEST FORM

***Please note:* If non-preferred drug is ordered, please include PDL (Preferred Drug List) form in addition to this request form.**

Consumer Name: _____ Date: _____/_____/_____

Consumer ID#: _____ Date Of Birth: _____/_____/_____

Drug Requested: _____NDC: _____

Pharmacy Name: _____ Provider Medicaid ID#: _____

Phone Number: (_____)_____ Fax Number: (_____)_____

Pediatric Endocrinologist Name : _____Provider Medicaid ID#: _____

Phone Number: (_____)_____ Fax Number: (_____)_____

Provider Contact Person: _____ Phone Number: (_____)_____

Please provide the following information with this form:

1. Evaluation by pediatric endocrinologist or pediatrician w/endocrinology only practice
2. Copy of growth curve
3. Radiological evidence of open epiphyseal growth plates for boys >16yrs age and for girls >15 yr age.
4. Additional labs if related to medical diagnosis (see criteria for Prader-Willi and Turner syndrome)
5. MRI, if required
6. Height velocity, target height, target height and percentiles (SD). Attach copy of printout to SMN. (recommend calculations be made using software designed for this purpose)

Please complete the following information:

1. Diagnosis for Growth Hormone Therapy: _____
2. Growth rate over 6 month period (please include 3 measurements in centimeters)

   Date_____/_____/_____ Height in centimeters_____

   Date_____/_____/_____ Height in centimeters_____

   Date_____/_____/_____ Height in centimeters_____

(Children Initial Growth Hormone Request Form continued)

3. T4 value_____ normal range_____ Date_____/_____/_____

4. TSH value_____ normal range_____ Date_____/_____/_____

5. IGF-1 or IGFBP-3 * value_____ normal range_____Date_____/_____/_____
   (*optional-confirmatory but not required)

6. Please indicate which agents were used for the stimulation studies and the peak value (should include two different secretagogues).
   Date _____/_____/_____ Please include normal ranges for this lab_____.

   _____L-Dopa_____ng/ml _____Insulin_____ng/ml _____Glucagon_____ng/ml

   _____Arginine_____ng/ml _____Clonidine_____ng/ml

Signature of Physician or Designee: _____

Completed form should be faxed to 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.
Initial prior authorization is for 6 months or at SRS Program Manager's discretion.